BEBTELOVIMAB

COVID -19 Monoclonal Antibody Therapy
Roster Order

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Facility's Name: ______________________________

Facility's Address: ______________________________

City: ____________________ County: ____________________

Telephone Number: ______________________________

INFUSION THERAPY ORDERS:

- Bebtelovimab 175mg/2ml
- Prepare and administer Bebtelovimab in alignment with manufacturer guidelines
- No routine premedications
- IV Line Care per Nursing Policy
- Infusion Reaction Medications per Standardized Procedures
- Monitor patient for adverse reaction during and one hour post administration

Bebtelovimab is not approved for Post Exposure Prophylaxis (PEP)

- Please fill in the roster order form for all COVID-19 positive patients being treated, if there are more than five patients use a second order form
- Send the roster order form to Total Infuison via fax **(510) 969-5840** or secure email **referrals@totalinfusion.com**
- Send the following documents with the roster order form:
  - Consent form(s)
  - Facility face sheet(s)
- Call Total Infusion **(510) 878-9528** if you have questions or need support with the process

DIAGNOSIS (ICD-10 code):
U07.1 COVID-19

Please place a "X" in box below for high risk criteria for each patient
(Other medical conditions or factors may also place individual patients at high risk for progression to severe COVID-19; authorization of Bebtelovimab under the EUA is not limited to the medical conditions or factors listed below. Physician may use clinical discretion in determining patient's risk.)

	Patient's Name:	Patient's DOB:	Full Code? (Yes/No)	O2 Dependent? (Yes/No)	COVID-19 Positive Test Result (Date)	Onset of Symptoms (Date)	Age>65	BMI>25	CKD	DM	CVD/HTN	Chronic Lung Disease	Neurodevelopmental Disorder	Medical Related Technological Dependence	Race/Ethnicity	Immunosuppressive Disease/tx	Unvaccinated	Other Medical Conditions
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		

Special Instruction(s):

Medical Director/Prescriber Signature: ____________________ NPI#: ____________ Date: ____________________

Printed Name: ______________________________ Phone: ____________ Email: ____________________

Director of Nursing/Point of Contact: ____________________ Phone: ____________ Email: ____________________